## Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

## Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500-SF.

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OMB Nos. 1210-0110 1210-0089

2012

This Form is Open to Public Inspection

| A This return/report is for:  B This return/report is:  the first return/report  an amended return/report  b short plan year return/report (less than 12 months)  C Check box if filing under:  Form 5558  special extension (enter description)  Part II Basic Plan Information—enter all requested information  1a Name of plan  NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC PROFIT SHARING 401(K) PLAN  1b Three-digit plan number (PN)    (PN)    001  1c Effective date of plan  001/01/2009  2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)  NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC  SOUTH STREET  GLENS FALLS, NY 12801  3a Plan administrator's name and address Same as Plan Sponsor Name Same as Plan Sponsor Address  3b Administrator's telephone number 518-792-7841  2d Business code (see instructions) 621111  3c Administrator's telephone number  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  a Sponsor's name  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  a Sponsor's name  5 Total number of participants at the end of the plan year.  C Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item).   | A This return/report is for:    A single-employer plan   a multiple-employer plan (not multiemployer)   a one-participant plan   a multiple-employer plan (not multiemployer)   a one-participant plan   the first return/report   de first return/report   de short plan year return/report (less than 12 months)   | A This return/report is for:  B This return/report is:  I the first return/report   the first return/report   the first return/report   the final return/report   the final return/report   a one-participant plan   an amended return/report   the final return/report   the final return/report   a short plan year return/report (less than 12 months)    C Check box if filing under:    Form 5558   automatic extension   DFVC program  | Part I Annual Report Identification Information |   |  |                              |                            |                          |                           |  |  |
|--|--|--|---|---|--|------------------------------|----------------------------|--------------------------|---------------------------|--|--|
| B This return/report is:   | B This return/report is:   | B This return/report is:   |   |   |  |                              |                            |                          |                           |  |  |
| C Check box if filling under:  | C Check box if filing under:   | C Check box if filing under:   | A This ref                                      | turn/report is for:   | rn/report is for: a single-employer plan a multiple-employer plan (not multiemployer) a one-participant plan |                              |                            |                          |                           |  |  |
| C Check box if filing under:   | C Check box if filing under:   | C Check box if filing under:   | <b>B</b> This ref                               | turn/report is:   | the first return/report th   | e final return/repor         | t                          |                          |                           |  |  |
| Special extension (enter description)   Part II  | Special extension (enter description)   Part     Basic Plan Information—enter all requested information   1a Name of plan   NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC PROFIT SHARING 401(K) PLAN   1c Effective date of plan number (PN)    001     1c Effective date of plan   0101/2009     2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)   2b Employer Identification Number (EIN) 26-2581213     2c Sponsor's telephone number   518-792-7841     2d Business code (see instructions)   6211111     3a Plan administrator's name and address   Same as Plan Sponsor Name   Same as Plan Sponsor Address   3b Administrator's telephone number   6211111     3c Administrator's telephone number   4b EIN   3c Administrator's telephone number   5a Total number of participants at the beginning of the plan year   5a   17   5b Total number of participants at the end of the plan year   5c   17   | Special extension (enter description)   Part II  |   |   | an amended return/report as  | short plan year retu         | rn/report (less than 12 r  | months)                  |                           |  |  |
| Part II   Basic Plan Information—enter all requested information   1a Name of plan   NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC PROFIT SHARING 401(K) PLAN   1c Effective date of plan on/101/2009   2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)   NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC   ORTHOROGY PLLC     2b Employer Identification Number (EIN)   26-2581213     2c Sponsor's telephone number   S18-792-7841     2d Business code (see instructions)   621111     3a Plan administrator's name and address   Same as Plan Sponsor Name   Same as Plan Sponsor Address   3b Administrator's telephone number   Administrator's telephone number   3c Administrator's telephone number   4d PN     4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.   4c PN     5a Total number of participants at the beginning of the plan year.   5b   17     b Total number of participants at the end of the plan year.   5b   17     c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item).   17   17   17   18   18   19   19   19   19   19   19  | Part II  | Part II   Basic Plan Information   | C Check   | box if filing under:  | Form 5558 au   | utomatic extension           |                            | DFVC                     | program                   |  |  |
| 1a Name of plan NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC PROFIT SHARING 401(K) PLAN  1c Effective date of plan 01/01/2009  2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC  2b Employer Identification Number (EIN) 2e-2581213  2c Sponsor's telephone number 518-792-7841  2d Business code (see instructions) 621111  3a Plan administrator's name and address Same as Plan Sponsor Name Same as Plan Sponsor Address  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  a Sponsor's name  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  a Sponsor's name  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number of participants at the beginning of the plan year.  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number of participants at the beginning of the plan year.  5 a 17  5 b 101 number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item).  | 1a Name of plan NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC PROFIT SHARING 401(K) PLAN  2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC  2b Employer Identification Number (EIN) 26-2581213  2c Sponsor's telephone number 518-792-7841  2d Business code (see instructions) 62/1111  3a Plan administrator's name and address Same as Plan Sponsor Name Same as Plan Sponsor Address  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  a Sponsor's name  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  a Sponsor's name  5a Interveloped the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number of participants at the beginning of the plan year.  5a Interveloped the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number of participants at the beginning of the plan year.  5a Interveloped the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number of participants at the beginning of the plan year.  5b Interveloped the EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number of participants at the beginning of the plan year.  5c PN  5c Interveloped the EIN of the plan year invested in eligible assets? (See instructions)  5c Interveloped the plan year invested in eligible assets? (See instructions)  6d Were all of the plan's assets during the plan year invested in eligible assets? (See instructions)  6d Were all of the plan's assets during the plan year invested in eligible assets? (See instructions)  6d Were all of the plan's assets  | 1  |   |   | special extension (enter description)  |                              |                            |                          |                           |  |  |
| Plan number (PN)   | NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC PROFIT SHARING 401(K) PLAN    1   | Plan number (PN) b 001  1c Effective date of plan O1/01/2009  2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC  2b Employer Identification Number (EIN) 26-2581213  2c Sponsor's stelephone number 518-792-7841  2d Business code (see instructions) 621111  3a Plan administrator's name and address Same as Plan Sponsor Name same as Plan Sponsor Address  3b Administrator's telephone number name, EIN, and the plan number from the last return/report.  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  4 Sponsor's name  4 PN  5a Total number of participants at the end of the plan year.  5 Total number of participants at the end of the plan year.  5 Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this fem).  5 Refer to the plan year invested in eligible assets? (See instructions).  6 Were all of the plan's assets during the plan year invested in eligible assets? (See instructions).  6 If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.  Caution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable causes is established.  Cludder penalties of perjury and other penalties of perjury and other penalties of perjury and other penalties set forth in the instructions, of lederate that I have examined this return/report, and to the best of my knowledge and belefic its true, correct and other penalties set forth in the instructions of the examined this return/report, and to the best of my knowledge and belefic its true, correct penalties of pelmy and other penalties of perjury an | Part II   | Basic Plan Inform   | nation—enter all requested information   | on                           |                            |                          |                           |  |  |
| CPN   001   1c   Effective date of plan   01/01/2009   2a   Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)   2b   Employer Identification Number (EIN)   26-2581213   2c   Sponsor's telephone number   518-792-7841   2d   Business Carde (see instructions)   621111   3a   Plan administrator's name and address   Same as Plan Sponsor Name   Same as Plan Sponsor Address   3b   Administrator's telephone number   3c   Plan administrator's telephone nu | 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC  2b Employer Identification Number (EIN) 26-2581213  2c Sponsor's telephone number 518-792-7841  2d Business code (see instructions) 621111  3a Plan administrator's name and address Same as Plan Sponsor Name same as Plan Sponsor Address  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  a Sponsor's name  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  a Sponsor's name  4 C PN  5a Total number of participants at the beginning of the plan year  | 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC  2b Employer Identification Number (EIN) 26-25812132 2c Sponsor's telephone number 518-792-7841 2d Business code (see instructions) 621111  3a Plan administrator's name and address Same as Plan Sponsor Name Same as Plan Sponsor Address  3b Administrator's EIN  3c Administrator's telephone number same, EIN, and the plan number from the last return/report.  a Sponsor's name  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  a Sponsor's name  4c PN  5a Total number of participants at the beginning of the plan year.  5 Total number of participants at the end of the plan year.  5 No Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this Item).  5 Were all of the plan's assets during the plan year invested in eligible assets? (See instructions).  6 Were all of the plan's assets during the plan year invested in eligible assets? (See instructions).  6 If you answered 'No' to either line & or line 6b, the plan cannot use Form 5500.  Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  Under penalties of perjuny and other penalties set forth in the instructions, I declare that have examined this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.  6 Signature of plan administrator  6 Date Enter name of individual signing as plan administrator  7 Po/26/2013 MICHAEL FINKOWSKI  |   |   |  |                              |                            |                          |                           |  |  |
| 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC  2b Employer Identification Number (EIN) 26-2581213  2c Sponsor's telephone number 518-792-7841  2d Business code (see instructions) 621111  3a Plan administrator's name and address Same as Plan Sponsor Name Same as Plan Sponsor Address  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  Sponsor's name  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  Sponsor's name  4c PN  5a 170tal number of participants at the beginning of the plan year.  5b 170tal number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item).   | 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC  2b Employer Identification Number (EIN) 26-2581213  2c Sponsor's telephone number 518-792-7841  2d Business code (see instructions) 621111  3a Plan administrator's name and address Same as Plan Sponsor Name Same as Plan Sponsor Address  3b Administrator's EIN  3c Administrator's telephone number 621111  4c PN  5a Total number of participants at the beginning of the plan year 64c PN  5a Total number of participants at the end of the plan year 64c PN  5a Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item). 5c 17  6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) 7c Party 100 Party 10 | 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC  2b Employer Identification Number (EIN) 26-2581213  2c Sponsor's telephone number 18-782-7841  2d Business code (see instructions) 621111  3a Plan administrator's name and address Same as Plan Sponsor Name same as Plan Sponsor Address  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  3 Sponsor's name  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  4 PN  5a Total number of participants at the beginning of the plan year.  5b 17  C Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this ferm).  6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions).  6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions).  6 Were all of the plan's assets during the plan year invested in eligible assets? (See instructions).  6 New you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 26 (FRE 255.104-46? (See instructions on waiver eligibility and conditions.)  6 If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.  6 Caution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established.  6 Caution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is establ | NORTH CO  | UNTRY OBSTETRICS &  | GYNECOLOGY PLLC PROFIT SHAR  | ING 401(K) PLAN              |                            | '                        |                           |  |  |
| 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)  NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC  2b Employer Identification Number (EIN) 26-2581213  2c Sponsor's telephone number 518-792-7841  2d Business code (see instructions) 621111  3a Plan administrator's name and address Same as Plan Sponsor Name Same as Plan Sponsor Address  3b Administrator's EIN  3c Administrator's telephone number name, EIN, and the plan number from the last return/report.  a Sponsor's name  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  a Sponsor's name  5a Total number of participants at the beginning of the plan year  | 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC  2b Employer Identification Number (EIN) 26-2581213  2c Sponsor's telephone number 518-792-7841  2d Business code (see instructions) 621111  3a Plan administrator's name and address Same as Plan Sponsor Name same as Plan Sponsor Address  3b Administrator's EIN  3c Administrator's telephone number  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  a Sponsor's name  4c PN  5a Total number of participants at the beginning of the plan year  | 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) NORTH-COUNTRY OBSTETRICS & GYNECOLOGY PLLC  2b Employer Identification Number (EIN) 26-2581213  2c Sponsor's telephone number 518-792-7841  2d Business code (see instructions) 621111  3a Plan administrator's name and address Same as Plan Sponsor Name same as Plan Sponsor Address  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the ame, EIN, and the plan number from the last return/report.  3 Sponsor's name  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the ame, EIN, and the plan number from the last return/report.  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the applications application of the plan number of participants at the beginning of the plan year.  5 Total number of participants at the beginning of the plan year.  5 Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item).  5 C Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item).  5 C 17  6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.).  5 C 17  6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.).  6a Very or claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 2e CFR 252.01-446? (See instructions on waiver eligiblity and conditions.).  6a Very or claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 2e CFR 252.01-446? (See instructions on waiver eligiblity and conditions.).  6a Very or claiming a waiver of the annual examination and report of an independent qualified public account |   |   |  |                              |                            |                          |                           |  |  |
| NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC  (EIN) 26-2581213  2c Sponsor's telephone number 518-792-7841  2d Business code (see instructions) 621111  3a Plan administrator's name and address Same as Plan Sponsor Name Same as Plan Sponsor Address  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  a Sponsor's name  4c PN  5a Total number of participants at the beginning of the plan year 5b 17  b Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)  5c 17  | NORTH COUNTRY OBSTETRICS & GYNECOLOGY PLLC  90 SOUTH STREET GLENS FALLS, NY 12801  2c Sponsor's telephone number 518-792-7841 2d Business code (see instructions) 621111  3a Plan administrator's name and address Same as Plan Sponsor Name Same as Plan Sponsor Address  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  3 Sponsor's name  4 EIN  4 C PN  5a Total number of participants at the beginning of the plan year  | Sont Honor Country Obstetrics & GYNECOLOGY PLLC  (EIN) 26-2581213  2c Sponsor's telephone number 518-792-7841  2d Business code (see instructions) 621111  3a Plan administrator's name and address Same as Plan Sponsor Name Same as Plan Sponsor Address  3b Administrator's EIN  3c Administrator's telephone number from the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  4c PN  5a Total number of participants at the beginning of the plan year.  5b 17  b Total number of participants at the end of the plan year.  5c 17  6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions).  5c 17  6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions).  6a Were all of the plan's assets during the plan vear invested in eligible assets? (See instructions).  6b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions).  6c If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.  6caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  6cution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  6cution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  6cution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  6cution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable c |   |   |  |                              |                            |                          | -                         |  |  |
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| South Street GLENS FALLS, NY 12801  3a Plan administrator's name and address Same as Plan Sponsor Name Same as Plan Sponsor Address  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  a Sponsor's name  4b EIN  4c PN  5a Total number of participants at the beginning of the plan year  | 90 SOUTH STREET GLENS FALLS, NY 12801  3a Plan administrator's name and address Same as Plan Sponsor Name Same as Plan Sponsor Address  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  a Sponsor's name  4c PN  5a Total number of participants at the beginning of the plan year   | Same as Plan Sponsor Address   Same as Plan Sponsor Name   Same as Plan Sponsor Address   Same Administrator's telephone number   Same as Plan Sponsor Address   Same Administrator's telephone number   Same Administrator   Same Adm   | NORTH CO  | UNIRY OBSIETRICS &  | GYNECOLOGY PLLC  |                              |                            |                          |                           |  |  |
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| a Sponsor's name  Total number of participants at the beginning of the plan year   | a Sponsor's name  5a Total number of participants at the beginning of the plan year  | Total number of participants at the beginning of the plan year   |   | •   |  | return/report filed          | for this plan, enter the   | <b>4b</b> EIN            |                           |  |  |
| Total number of participants at the beginning of the plan year   | Total number of participants at the beginning of the plan year   | Total number of participants at the beginning of the plan year   |   |   | er from the last return/report.  |                              |                            | 4c PN                    |                           |  |  |
| b Total number of participants at the end of the plan year   | b Total number of participants at the end of the plan year   | b Total number of participants at the end of the plan year   | <b>5a</b> Total                                 | number of participants at   | the beginning of the plan year   |                              |                            | + -                      | 17                        |  |  |
| complete this item)  | complete this item)  | Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.  Signature of plan administrator  Date  Enter name of individual signing as plan administrator  Filed with authorized/valid electronic signature.  07/26/2013  MICHAEL FINKOWSKI  | <b>b</b> Total                                  | number of participants at   | the end of the plan year   |                              |                            | <del> </del>             | 17                        |  |  |
|  | Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)  Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)  Yes No  No  If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.   | Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)  | C Numb  | er of participants with acc                                       | count balances as of the end of the pla  | n year (defined ber          | nefit plans do not         | _                        |                           |  |  |
|  | b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)   | Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)   |   | •   |  |                              |                            | l l                      | п., п.,                   |  |  |
| The first the plant access during the plant year invested in engine access. (ever instruction)   | under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)   | under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)   |   |   |  |                              |                            |                          | X Yes   No                |  |  |
|  | If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.  | If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.  Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.  SIGN HERE  Filed with authorized/valid electronic signature.  O7/26/2013  MICHAEL FINKOWSKI  Signature of plan administrator  Date  Enter name of individual signing as plan administrator  MICHAEL FINKOWSKI  MICHAEL FINKOWSKI   |   |   |  |                              |                            |                          | X Yes No                  |  |  |
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|  | Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule  | SIGN   Filed with authorized/valid electronic signature.   07/26/2013   MICHAEL FINKOWSKI  |   |   |  |                              |                            |                          |                           |  |  |
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Form 5500-SF 2012 Page **2** 

| Pa   |   |             |                                 |         | 1       | (b) End of Year |               |                  |       |       |  |
|--|---|-------------|---------------------------------|---------|---------|-----------------|---------------|------------------|-------|-------|--|
| 7  | Plan Assets and Liabilities   | _           | (a) Beginning of Yea            |         |         |                 | (b) End o     |                  |       |       |  |
|  | Total plan assets   | 7a<br>      | 58512                           | 23      | -       |                 |               | 7750             | 000   |       |  |
|  | Total plan liabilities  | 7b          | 50546                           |         |         |                 |               |                  |       |       |  |
|  | Net plan assets (subtract line 7b from line 7a)   | 7c          | 58512                           | 23      |         | 775000          |               |                  |       |       |  |
| 8  | Income, Expenses, and Transfers for this Plan Year  |             | (a) Amount                      |         |         |                 | (b) To        | tal              |       |       |  |
| а  | Contributions received or receivable from:  (1) Employers   | 8a(1)       | 3229                            | )1      |         |                 |               |                  |       |       |  |
|  | (2) Participants  | 8a(2)       | 8166                            | 66      |         |                 |               |                  |       |       |  |
|  | (3) Others (including rollovers)  | 8a(3)       |                                 |         |         |                 |               |                  |       |       |  |
| b  | Other income (loss)   | 8b          | 8544                            | 13      |         |                 |               |                  |       |       |  |
|  | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)  | 8c          |                                 |         |         |                 |               | 1994             | 100   |       |  |
|  | Benefits paid (including direct rollovers and insurance premiums to provide benefits)   | 8d          | 921                             | 2       |         |                 |               |                  |       |       |  |
| е  | Certain deemed and/or corrective distributions (see instructions)   | 8e          |                                 |         |         |                 |               |                  |       |       |  |
| f  | Administrative service providers (salaries, fees, commissions)  | 8f          | 31                              | 1       |         |                 |               |                  |       |       |  |
| g  | Other expenses  | 8g          |                                 |         |         |                 |               |                  |       |       |  |
| h  | Total expenses (add lines 8d, 8e, 8f, and 8g)   | 8h          |                                 |         |         |                 |               | 9                | 523   |       |  |
| <u>i</u>   | Net income (loss) (subtract line 8h from line 8c)   | 8i          |                                 |         |         |                 |               | 189              | 877   |       |  |
| j  | Transfers to (from) the plan (see instructions)   | 8j          |                                 |         |         |                 |               |                  |       |       |  |
| Pai  | rt IV Plan Characteristics  |             |                                 |         |         |                 |               |                  |       |       |  |
| 9a   | If the plan provides pension benefits, enter the applicable pension 2E 2F 2G 2J 2T 3B 3D  | feature co  | des from the List of Plan Char  | acteris | stic Co | des in          | the instructi | ons:             |       |       |  |
| b  | If the plan provides welfare benefits, enter the applicable welfare for   | eature cod  | les from the List of Plan Chara | cterist | ic Cod  | les in t        | he instructio | าร:              |       |       |  |
| Par  | t V Compliance Questions  |             |                                 |         |         |                 |               |                  |       |       |  |
| 10   | During the plan year:   |             |                                 |         | Yes     | No              |               | lmoun            | t     |       |  |
| а  | Was there a failure to transmit to the plan any participant contribute 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidure) |             |                                 | 10a     |         | X               |               |                  |       |       |  |
| b  | Were there any nonexempt transactions with any party-in-interest on line 10a.)  |             |                                 | 10b     |         | X               |               |                  |       |       |  |
|  | Was the plan covered by a fidelity bond?  |             |                                 | 10c     | X       |                 |               |                  | ,     | 20000 |  |
| d  | Did the plan have a loss, whether or not reimbursed by the plan's or dishonesty?  |             |                                 | 10d     |         | X               |               |                  |       | 20000 |  |
|  | Were any fees or commissions paid to any brokers, agents, or oth  |             |                                 | 100     |         |                 |               |                  |       |       |  |
| C  | insurance service or other organization that provides some or all of  |             |                                 |         |         | V               |               |                  |       |       |  |
|  | instructions.)  |             |                                 | 10e     |         | X               |               |                  |       |       |  |
| f  | Has the plan failed to provide any benefit when due under the plan  | n?          |                                 | 10f     |         | X               |               |                  |       |       |  |
| g  | Did the plan have any participant loans? (If "Yes," enter amount a  | s of year e | end.)                           | 10g     |         | X               |               |                  |       |       |  |
| h  | If this is an individual account plan, was there a blackout period? (2520.101-3.)   | •           |                                 | 10h     |         | X               |               |                  |       |       |  |
| i  | If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.10     |             |                                 | 10i     |         |                 |               |                  |       |       |  |
| Part   | VI Pension Funding Compliance   |             |                                 |         |         |                 |               |                  |       |       |  |
| Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and line 11a below) |   |             |                                 |         |         |                 | X No          |                  |       |       |  |
| 11a  | 1a Enter the amount from Schedule SB line 39  |             |                                 |         |         | 11a             |               |                  |       |       |  |
| 12   |   |             |                                 |         | •       |                 | ERISA?        | T Y              | es )  | X No  |  |
|  | (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)   |             |                                 |         |         |                 |               |                  |       |       |  |
| а  | a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instrugranting the waiver      |             |                                 |         |         | enter th<br>Day |               | e letter<br>Year | rulin | g     |  |
| If   | you completed line 12a, complete lines 3, 9, and 10 of Schedule   |             |                                 |         |         |                 |               |                  |       |       |  |
| b  | Enter the minimum required contribution for this plan year  |             |                                 |         |         | 12b             |               |                  |       |       |  |

|      | Form 5500-SF 2012 Page <b>3</b> - 1  |                  |            |                     |
|------|--|------------------|------------|---------------------|
|      | Enter the amount contributed by the employer to the plan for this plan year  | 12c              |            |                     |
| d    | Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)  | 12d              |            |                     |
| е    | Will the minimum funding amount reported on line 12d be met by the funding deadline?   |                  | Yes        | No N/A              |
| Part | VII Plan Terminations and Transfers of Assets  |                  |            |                     |
| 13a  | Has a resolution to terminate the plan been adopted in any plan year?  |                  | Yes X No   |                     |
|      | If "Yes," enter the amount of any plan assets that reverted to the employer this year  | . 13a            |            |                     |
| b    | Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the of the PBGC?  | control          |            | Yes X No            |
| С    | If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) which assets or liabilities were transferred. (See instructions.) | to               |            |                     |
| 1    | 3c(1) Name of plan(s):   | 1 <b>3c(2)</b> E | IN(s)      | <b>13c(3)</b> PN(s) |
| Part | VIII Trust Information (optional)  |                  |            |                     |
|      | Name of trust  | <b>14b</b> ⊤     | rust's EIN |                     |